

INFORMATION PAPER

SUBJECT: Affirmative claims

1. PURPOSE: To provide general guidance on the collection of Affirmative Claims on behalf of the Army and explain how claims are to be processed. Soldiers, retirees and their eligible dependents are required to provide information concerning possible claims in favor of the government for medical care furnished and for lost wages caused by the wrongful or negligent acts or omissions of others.

2. FACTS:

a. The Army has the right to assert a claim for the cost of medical care provided by military medical treatment facilities (MTF's) and for the lost wages of the Soldier resulting from the negligence of the tortfeasor. The Army also has the right to recover the cost of medical care provided to dependents and retirees. The Fort Polk Claims Office asserts affirmative claims against tortfeasors and their insurers, insurance companies, medical coverage and uninsured/underinsured motorist coverage for the cost of medical care provided by MTF's and payments made by CHAMPUS/TRICARE. The money recovered goes back into the system to provide quality care for Soldiers, retirees and dependents.

b. Individuals who have been injured and received healthcare benefits under the provisions of the CHAMPUS, or from the local MTF and its referrals administered by TRICARE, are required to furnish such information as may be requested concerning the circumstances giving rise to the injury for which the medical care has been given.

c. Soldiers who do not cooperate by providing the information necessary for investigation of the claim are subject to disciplinary action under the UCMJ. Retirees, civilian employees and dependents of eligible recipients of medical care are subject to loss of medical care under CHAMPUS/TRICARE or through MTF's for failure to cooperate and provide necessary information for investigation of the claim.

d. If contacted by an insurance company individuals should not execute a release or settle any claim for which they have received treatment either under CHAMPUS/TRICARE or from a MTF for injuries without first notifying the Fort Polk Affirmative Claims section (337) 531-2636, Building 1454, 7090 Alabama Avenue, Fort Polk, Louisiana.

3. CONCLUSION. The Fort Polk Claims Office asserts affirmative claims on behalf of Bayne Jones Army Community Hospital (BJACH), TRICARE, and the Department of the Army for medical care furnished to Soldiers, retirees and family members. This protects the Army's financial interest and improves quality of care provided to Soldiers, retirees and dependents.

**CODE OF FEDERAL REGULATIONS
TITLE 32 – NATIONAL DEFENSE**

**PART 220 – COLLECTION FROM THIRD PARTY PAYERS OF REASONABLE
COSTS OF HEALTHCARE SERVICES**

§220.9 Rights and obligations of beneficiaries.

(a) *No additional cost share.* Pursuant to 10 U.S.C. 1095(a)(2), uniformed services beneficiaries will not be required to pay to the facility of the uniformed services any amount greater than the normal medical services or subsistence charges (under 10 U.S.C. 1075 or 1078). In every case in which payment from a third party payer is received, it will be considered as satisfying the normal medical services or subsistence charges, and no further payment from the beneficiary will be required.

(b) *Availability of healthcare services unaffected.* The availability of healthcare services in any facility of the Uniformed Services will not be affected by the participation or nonparticipation of a Uniformed Services beneficiary in a health care plan of a third party payer. Whether or not a Uniformed Services beneficiary is covered by a third party payer's plan will not be considered in determining the availability of healthcare services in a facility of the Uniformed Services.

(c) *Obligation to disclose information and cooperate with collection efforts.* (1) Uniformed Services beneficiaries are required to provide correct information to the facility of the Uniformed Services regarding whether the beneficiary is covered by a third party payer's plan. Such beneficiaries are also required to provide correct information regarding whether particular health care services might be covered by a third party payer's plan, including services arising from an accident or workplace injury or illness. In the event a third party payer's plan might be applicable, a beneficiary has an obligation to provide such information as may be necessary to carry out 10 U.S.C. 1095 and this part, including identification of policy numbers, claim numbers, involved parties and their representatives, and other relevant information.

(2) Uniformed Services beneficiaries are required to take other reasonable steps to cooperate with the efforts of the facility of the Uniformed Services to make collections under 10 U.S.C. 1095 and this part, such as submitting to the third party payer (or other entity involved in adjudicating a claim) any requests or documentation that might be required by the third party payer (or other entity), if consistent with this part, to facilitate payment under this part.

(3) Intentionally providing false information or willfully failing to satisfy a beneficiary's obligations are grounds for disqualification for health care services from facilities of the Uniformed Services.

(d) *Mandatory disclosure of Social Security account numbers.* Pursuant to 10 U.S.C. 1095(k)(2), every covered beneficiary eligible for care in facilities of the Uniformed Services is, as a condition of eligibility, required to disclose to authorized personnel his or her Social Security account number.



STATEMENT OF INCIDENT - QUESTIONNAIRE -

DATA REQUIRED BY THE PRIVACY ACT OF 1974 (5 U.S.C., Section 552a)

RETURN TO: Office of the Staff Judge Advocate, Claims Division, 7090 Alabama Ave. Building 1454, Fort Polk, LA 71459

1. **AUTHORITY:** The Federal Medical Care Recovery Act, 42 U.S.C. Sections 2651 to 2653, Executive Order 9397, 10 U.S.C. Sections 1095 and 1095b, 32 C.F.R. Section 220.9, 5 U.S.C. Section 301, 44 U.S.C. Section 3101.
2. **PRINCIPAL PURPOSE (S):** To obtain information required enabling the United States to recover the reasonable value of Government-sponsored medical care furnished at its expense from third parties.
3. **ROUTINE USES:** a. Identify injured party and nature of injuries. b. Identify persons involved, including witnesses and other interested parties. c. Determine the circumstances of incidents, which give rise to personal injuries. d. Determine insurance coverage and source(s) of medical treatment. Information may be disclosed to civilian attorneys, insurance companies and other agencies to settle claims, and/or to the Department of Justice for use in litigation, and may be furnished to other components of the Department of Defense as required by regulation.
4. **MANDATORY OR VOLUNTARY DISCLOSURE:** MANDATORY DISCLOSURE. Failure to provide all pertinent information in a timely manner will result in the potential disqualification or suspension of all Government-sponsored health care at the discretion of the Secretary of Defense for Health Affairs, TRICARE, as well as the immediate withholding of military medical records pertaining to the incident from the injured beneficiary and/or their legal representative.

INSTRUCTIONS FOR COMPLETION

You must provide all information which pertains to the circumstances of your injury. For sections which do not apply to you, please mark "N/A" (Not Applicable) in the space provided. Attach documents supporting your statement. The regulation that requires completion of this form applies equally to active, retired, or separated United States military personnel and/or their family members.

INJURED PARTY

NAME (Last, First, MI)	DATE OF BIRTH	SOCIAL SECURITY #
HOME ADDRESS	HOME TELEPHONE	WORK TELEPHONE

MILITARY SPONSOR

BRANCH OF SERVICE (Delete all non-applicable branches)	SPONSOR'S STATUS AT TIME OF INJURY (Delete non-applicable statuses)		
USA USAF USN USMC OTHER (SPECIFY)	ACTIVE DUTY	RETIRED	ETS'd DECEASED
NAME (Last, First, MI)	GRADE/RANK		SPONSOR'S SSN
MILITARY UNIT MAILING ADDRESS (If sponsor is on active duty)			SPONSOR'S WORK PHONE

DETAILS OF THE INCIDENT

DATE (dd/mm/yyyy)	TIME (24 hour clock)	COUNTY
STREET (if known)	CITY	STATE
DID THE POLICE RESPOND? (Type Y, N, or n/a)		POLICE RESPONDER (MILITARY or CIVILIAN)?
IF YES, NAME OF AGENCY	TRAFFIC ACCIDENT REPORT #	ACCIDENT REPORT COMPLETED? (Y/N)
		IF YES, IS IT ATTACHED? (Y/N)
WAS TICKET ISSUED? (Y/N or n/a)	IF YES, AGAINST WHOM?	CITED FOR

IN YOUR OWN WORDS, please describe: 1) How the accident occurred. (2) How you came to be injured; (3) Who (if anyone) was at fault. (Please PRINT; use additional page if necessary)

IMPORTANT: COMPLETE EACH PAGE AND RETURN THE QUESTIONNAIRE TO THE ADDRESS ABOVE.

MOTOR VEHICLE ACCIDENTS

IMPORTANT: Notify your own insurance carrier even though the injured party was a pedestrian, a passenger in another vehicle, a victim of a "hit and run" incident, a bicyclist, or was involved in a one-vehicle accident. Failure to do so may jeopardize any right of recovery you have or the rights of the United States Government. Direct any questions to the military legal office coordinating recovery of the Government's claim.

I WAS A: (Delete non-applicable statuses) : **DRIVER** **PASSENGER** **PEDESTRIAN** **BICYCLIST**
OTHER (Specify):

	YEAR	MAKE	MODEL
INJURED PARTY'S VEHICLE			
NAME OF DRIVER	ADDRESS		
NAME OF OWNER (if different than the driver)	ADDRESS (if different than the driver)		
INSURANCE COMPANY	ADDRESS		
NAME OF CLAIMS ADJUSTER	CLAIMS ADJUSTER'S PHONE #		
POLICY #	INSURER CLAIM #		
IS A COPY OF THE AUTO POLICY ATTACHED? (Type "Yes," "No," or "Uninsured motorist")			
POLICY COVERAGE: Indicate coverage amounts for those which apply:	Personal Injury Protection (PIP) Coverage Amount? \$ _____	Medical Payments (Med Pay) Coverage Amount? \$ _____	Uninsured/Underinsured Motorist (UM/UIM) Coverage Amount? \$ _____

	YEAR	MAKE	MODEL
AT FAULT PARTY'S VEHICLE			
NAME OF AT FAULT DRIVER	ADDRESS		
NAME OF VEHICLE'S OWNER (if known)	ADDRESS		
AT FAULT DRIVER'S INSURANCE COMPANY	ADDRESS		
AT FAULT DRIVER'S CLAIMS ADJUSTER	CLAIMS ADJUSTER'S PHONE #		
POLICY # OF AT FAULT DRIVER	CLAIM # OF AT FAULT DRIVER		
POLICY COVERAGE FOR AT FAULT VEHICLE List coverage amounts	LIABILITY COVERAGE (Per Person / Per Accident) \$ _____ / \$ _____	* * * NOTE * * * IF THIS WAS A <u>MULTIPLE VEHICLE ACCIDENT</u> , PLEASE LIST INFORMATION CORRESPONDING TO ANY AND ALL ADDITIONAL VEHICLES ON A SEPARATE SHEET.	

ON-THE-JOB INJURY & WORKER'S COMPENSATION CLAIMS

NAME OF BUSINESS/ORGANIZATION	ADDRESS
EMPLOYER'S INSURANCE COMPANY	ADDRESS
NAME OF CLAIMS ADJUSTER	CLAIMS ADJUSTER'S TELEPHONE NUMBER
WORKER'S COMPENSATION CLAIM NUMBER	OTHER INFORMATION

OTHER TYPES OF INCIDENTS:

INJURY OCCURRED AT (delete non-applicable statuses)					
	MY HOME	OTHER RESIDENCE	SCHOOL	PUBLIC PROPERTY	PRIVATE PROPERTY
NAME OF PROPERTY OWNER	ADDRESS				
NAME OF INSURANCE COMPANY	ADDRESS				
NAME OF CLAIM ADJUSTER	CLAIM ADJUSTER'S TELEPHONE NUMBER				
INSURANCE POLICY NUMBER	INSURANCE CLAIM NUMBER				

YOUR MEDICAL CONDITION

WERE YOU INJURED IN THE ACCIDENT? (Y / N) IF "YES," DESCRIBE YOUR INJURIES _____

IMPORTANT: (Please *be specific* when describing the nature and severity of your illness/injuries, include "Left" or "Right," when specifying the body location. Also indicate if any surgeries or tests have been performed or *will be performed*)(Use additional page if needed.)

LIST BELOW THE NAMES OF **MILITARY FACILITIES** & DATES YOU WERE TREATED FOR THE ACCIDENT

MILITARY FACILITIES (installation & state)	CLINIC(S) TREATED AT	OUTPATIENT (Dates of Visits)	INPATIENT (Dates of Stay)

LIST BELOW THE NAMES OF **CIVILIAN FACILITIES** & DATES YOU WERE TREATED FOR THE ACCIDENT:

CIVILIAN FACILITIES (or Doctor's Name)	CLINIC(S)	OUTPATIENT (Dates of Visits)	INPATIENT (Dates of Stay)

HAVE THE CIVILIAN MEDICAL BILLS BEEN PAID (Y or N) (IF "Yes," please specify <i>by whom</i>): ▶	ME	ARMY	TRICARE (CHAMPUS)	INSURANCE	ATTORNEY	OTHER
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IMPORTANT: Initial here if you received **NO** civilian medical treatment for this incident: _____
[initials]

MISCELLANEOUS INFORMATION (Required)	PLEASE SPECIFY:
Do you <i>hand-carry</i> your medical record? (Y or N)	If "No," Where <i>is it on file</i> ?
Are you still receiving treatment? (Y or N)	If "No," <i>Date you were released</i> ?
Have you signed any release form? (Y or N)	If "Yes," <i>For whom</i> ?
Has property damage been paid? (Y or N)	If "Yes," <i>By whom</i> ?
Has personal injury been paid? (Y or N)	If "Yes," <i>By whom</i> ?
Were you placed on Quarters? [*] (Y or N)	If "Yes," <i>List dates</i> :

[*] **NOTE:** *Active Duty* members who missed entire duty days **MUST** submit a copy of their **Leave and Earnings Statement (LES)** and complete a "**CERTIFICATION STATEMENT**" of *Military Services Lost Due to Third Party Incident*" (attached).

YOUR ATTORNEY

LAW FIRM NAME	ADDRESS	
ATTORNEY'S NAME	ATTORNEY'S PHONE	ATTORNEY'S FAX

INITIAL HERE IF YOU HAVE NOT RETAINED THE SERVICES OF AN ATTORNEY CONCERNING THIS INCIDENT: _____

INJURED PARTY'S STATEMENT AND SIGNATURE

UNDER PENALTY OF PERJURY, I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, CORRECT, AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT USE OF THIS INFORMATION IS AUTHORIZED BY LAW IN PURSUING MEDICAL CLAIMS IN FAVOR OF THE U.S. GOVERNMENT.

DATE SIGNED (dd/mm/yyyy)	INJURED PARTY'S SIGNATURE (Parent's Signature, if injured party is a minor)
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PLEASE ATTACH ANY & ALL AVAILABLE DOCUMENTS FOR REVIEW BY THE RECOVERY ATTORNEY OR JUDGE ADVOCATE:

- ▶ Traffic Accident Report
- ▶ Auto Accident Diagram
- ▶ Insurance Policy Copy
- ▶ Leave & Earnings Statement (LES) [*]
- ▶ Copies of Hand-carried Military Medical Record
- ▶ Other Document(s)

MEDICAL RELEASE AUTHORIZATION

DATA REQUIRED BY THE PRIVACY ACT OF 1974 (5 United States Code, Section 552a)

1. **AUTHORITY:** The Federal Medical Care Recovery Act, 42 U.S.C. Sections 2651 to 2653, 10 U.S.C. Sections 1095 and 1095b, 32 C.F.R. Part 220.9, 5 U.S.C. Section 301, 44 U.S.C. Section 3101.
2. **PRINCIPAL PURPOSE(S):** Authorization for release of medical record excerpts in order to document the claim of the United States Government against third parties for medical care recovery costs.
3. **ROUTINE USES:** Information may be disclosed to civilian attorneys, insurance companies and other agencies to settle claims, and/or to the Department of Justice for use in litigation, and may be furnished to other components of the Department of Defense as required by regulation.
4. **MANDATORY OR VOLUNTARY DISCLOSURE:** Voluntary. However, eligible recipients of Government-sponsored medical treatment electing not to provide this information will be required to assign in writing any other claim against any other party as a result of the incident giving rise to the Government's claim for the recovery of medical care costs.

Patient's Name (Last, First, MI): _____

Date of Birth (mm/dd/yyyy): ____ / ____ / _____

Military Sponsor's Name (Last, First, MI): _____

Military Sponsor's Social Security Number: _____

I, _____, request and authorize you to furnish to the office handling the Government claim any and all medical, dental, psychological, and related information requested, including prescriptions and x-rays, concerning the third-party liability incident which occurred on or about (mm/dd/yyyy): ____ / ____ / _____

I understand this information/documentation will be used solely and exclusively for the purpose of obtaining full recovery of civilian or military medical care paid for or furnished by the United States Government as a result of this incident.

Photocopies of this authorization shall have the same validity as the original.

This authorization remains in effect unless I cancel it in writing.

Date Signed

Patient's Signature

(Parent's Signature if Injured Party is a Minor)



**CERTIFICATION STATEMENT
OF MILITARY SERVICES LOST
DUE TO THIRD PARTY LIABILITY INCIDENT
STATUTORY AUTHORITY**

The Federal Medical Care Recovery Act, 42 United States Code, Sections 2651 to 2653, allows the United States Government to recover the "costs of pay" from an insurer when an active duty member is negligently injured by another and, as a result, is unable or unavailable to perform assigned military duties (for complete duty days). This section also permits such recovery without a finding of tort liability in no-fault jurisdictions. Such a claim for lost military pay/services is that of the United States and not that of the injured service member.

IMPORTANT: Send completed form to the military legal office handling assertion of the Government's claim.

INJURED PARTY (Last, First, MI)	RANK	DATE OF ACCIDENT	ARMY CLAIM NUMBER (if known)

ITEMIZATION OF DUTY DAYS MISSED

INITIAL HERE IF YOU LOST NO TIME AWAY FROM MILITARY DUTIES AS A RESULT OF THIS THIRD PARTY LIABILITY INCIDENT: _____ (OTHERWISE, FILL IN INFORMATION BELOW):

I, as an active duty service member, was unable and/or unavailable to perform my assigned military duties for the specific time period(s) listed below (count complete duty days only):

MEDICAL STATUS	# OF DAYS	DATE(S)
Quarters Status <i>(issued by a military physician)</i>		
"Off Work Excuse" <i>(issued by a civilian physician)</i>		
Military Inpatient Hospital Stay		
Civilian Inpatient Hospital Stay		
Same Day Surgery Stay		
Convalescent Leave Status		
Subsisting Elsewhere Status <i>(pending a Medical Evaluation Board)</i>		
Individual duty days missed <u>in their entirety</u> due to traveling to, and/or submitting to, necessary medical treatment or tests as a result of the incident		
OTHER: (Specify):		
TOTAL FULL DUTY DAYS MISSED BECAUSE OF INCIDENT:		

I WAS ASSIGNED TO THE FOLLOWING MILITARY UNIT DURING THE TIME PERIODS INDICATED ABOVE:
(Information will be used to ensure proper return of funds to the appropriation supporting the installation to which I was assigned at the time of the injury)

NAME OF UNIT	MAILING ADDRESS	TELEPHONE NUMBER
NAME OF UNIT BUDGET OFFICER	BUDGET OFFICER'S PHONE NUMBER	

CERTIFICATION STATEMENT

UNDER THE PENALTY OF PERJURY, I have completed this form and certify that the information I have provided is true and complete to the best of my knowledge and belief. I further acknowledge that Federal Laws (18 United States Code, Sections 287 and 1001) provide for criminal penalties for knowingly submitting or making any false, fictitious, or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States of America. I understand that this information will be used by the Government to pursue and recover the "costs of pay" relating to military services lost as a result of the incident from the legally-responsible party and/or that party's insurance company.

INJURED SOLDIER'S SIGNATURE	DATE SIGNED

REMINDER: Please attach a legible copy of a DFAS Form 702 (Leave and Earnings Statement (LES))

AGREEMENT OF CLAIM

Pursuant to the Federal Medical Care Recovery Act, 42 U.S.C. 2651-2653, I hereby assign to the United States of America and its representative's any and all claims and benefits for the cost of medical care provided at the expense of the United States for injuries sustained on _____ at _____.

The United States is authorized to recover said costs independently of any claim for pain and suffering, consequential, special or punitive damages which I may have as a result of this incident, from any and all sources to which I may submit such claims for medical costs. The United States is authorized to act in my stead in completing any and all actions necessary to claim said cost. No release signed by myself, or my representatives shall operate to the prejudice of the United States.

Payment of the costs of such care described above shall be made directly to the United States per direction of the Department or Agency concerned. Payment made directly to me for medical care paid or furnished by the United States, without the express consent of the United States.

Because this assignment is mandated by Federal Regulations (2 C.F.R. 43.2), it may not be revoked except with the express consent of the United States.

DATE

SIGNATURE

ADVICE TO INJURED PARTIES

1. Under federal law, the United States may be entitled to recover the reasonable value of medical care provided or to be provided to you. This claim would be asserted against the person responsible for your injury.
2. You may seek guidance from a legal assistance attorney regarding any cause of action you may have for personal injury.
3. You are required to cooperate with the Claims Judge Advocate as he or she processes the United States government's claim.
4. You are required to furnish a complete statement regarding the circumstances surrounding the incident that resulted in your injury. Completing the enclosed Medical Care Recovery Program Injury Information Paper (Statement of Incident) will satisfy this requirement.
5. You are required to furnish the Claims Judge Advocate information concerning any legal action brought or to be brought by or against the person responsible for your injury. You are also required to provide the Claims Judge Advocate the name and address of your attorney.
6. Your failure to cooperate with the Claims Judge Advocate may result in the hospital withholding your medical records from you or your attorney and disqualifying you for future health care services.
7. You should not execute a release or settle any claims you may have as a result of the injury without first notifying the Claims Judge Advocate.

I, _____, have carefully read and understand the above information. I understand I must promptly return one signed copy of this form along with a signed Medical Release to:

Office of the Staff Judge Advocate
Claims Division
7090 Alabama Avenue, Building 1454
Fort Polk, Louisiana 71459

Date

Signature

Date

Signature

Date

Signature